

## **NEBRASKA MENTAL HEALTH CENTERS - Confidential Intake Form**

<b><u>Name (First, Middle Initial, Last):</u></b>		Gender M F	Birthdate (mm/dd/yyyy):
Street Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
Social Security Number:		Marital Status: S M W D	Email Address:
Employer:		Full-time Part-time	Employer Address:
Education Level (highest grade completed):		Student Now? Yes No	School:
Have you (patient) had previous counseling? Yes No		If yes, please tell us when and with whom:	
Emergency Contact (name, relationship, address, phone):			How did you hear about us?
Military Service: Yes No		If Discharged, please choose one of the following: Honorable Medical Dishonorable	

### **Parent / Legal Guardian Information** (for patients under 19yrs of age, elderly, mentally disabled, etc)

<b><u>Parent/Guardian Name (First, Middle Initial, Last):</u></b>		Relationship to Patient:	
Street Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
<b><u>Parent/Guardian Name (First, Middle Initial, Last):</u></b>		Relationship to Patient:	
Street Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:

### **Insurance Plan Information**

<b><u>Primary Plan Name:</u></b>	Phone #:	Policy #:	Group #:
Policy Holder Name:		Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to patient:	
<b><u>Secondary Plan Name:</u></b>	Phone #:	Policy #:	Group #:
Policy Holder Name:		Birthdate (mm/dd/yyyy):	Social Security Number:
Policy Holder's Employer:		Relationship to patient:	